Access to Health Care and The Status of the Cal-Mortgage Loan Insurance Program

A Post Hearing Report of the Joint Legislative Audit Committee

Assemblymember Scott Wildman, Chair

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Background

In 1968, California voters authorized a program to guarantee loans to nonprofit and public corporations committed to health care and added Article 16, Section 4 to the California Constitution. The program became known as the Cal-Mortgage Loan Insurance Program.

The program's intent, codified in California Health and Safety Codes 12900-129040, is to

> *"rationally meet the need for new, expanded and modernized public and nonprofit health facilities necessary to protect the health of all the people of this state."*[1]

Its intent is further articulated in Health and Safety Codes, which requires that the administrators of the Cal-Mortgage Program, the Office of Statewide Health Planning and Development (OSHPD)

> *"implement the loan insurance program … so that in conjunction with all other existing facilities … . the necessary physical facilities for furnishing adequate health facility services will be available to all the people of the state."*[2]

The codes stipulate, however, that the program be administered *"without cost to the state."*[3]

Generally, the Cal-Mortgage program guarantees loans to non-profit and public higher risk borrowers *"for the construction, improvement and expansion of public and nonprofit corporation health facilities."*[4] The program answers needs for two types of borrowers -- those who either can not obtain commercial loans without state-backed insurance or those who need state backing to obtain better credit ratings and interest rates.

In its 30 years of existence, approximately $4 billion in loans have been insured to more than 400 health care facilities, according to testimony from Dr. David Werdeger, Director of the Office of Statewide Health Planning and Development (OSHPD), which administers the Cal-Mortgage program.[5]

With an initial appropriation of $1 million, the program generated its own reserves of approximately $130 million, Werdeger said. And until 1992, it appears that no borrowers using Cal-Mortgage loan insurance had defaulted on their state-backed loans.[6] However, beginning in 1992, a series of seven borrowers have defaulted on their loans, leaving the State of California, through Cal-Mortgage, responsible for the repayment of their debts. One borrower, the Los Medanos Health Care Corporation, defaulted on an $11 million loan in January 1994 and subsequently filed for Chapter 9 bankruptcy in April 1994.[7] A larger default by Triad Healthcare Corporation left a principle balance of $182 million and entangled OSHPD and the State of California in litigation.

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[1] California Health and Safety Code, Section 129005
[2] California Health and Safety Code, Section 129020
[3] California Health and Safety Code, Section 129005
[4] California Health and Safety Code, Section 129020
[5] Werdeger oral testimony, January 20, 1999, JLAC Hearing on Cal-Mortgage
[6] ibid
[7] October 1998 State Auditor's report

These and other defaults led legislators to direct the State Auditor to conduct a performance audit of the Cal-Mortgage Program and the Office of Statewide Health Planning and Development in an effort to better understand its methodologies and performance, and improve its effectiveness.

In October 1998, the Bureau of State Audits completed its audit and released its findings, which in summary, stated that the Cal-Mortgage program needs remediation, particularly in three key areas: Its evaluation of borrowers, information gathering procedures and debt monitoring practices. Specifically, the California State Auditor, Kurt Sjoberg, noted weaknesses both in the program's fulfillment of its mission and in its efforts to protect the State's resources. He wrote,

> *"Cal-Mortgage still cannot assure that applicants serve all persons . . . as the law requires. . . . It [Cal-Mortgage] has not used all available information to assess an applicant's financial viability, nor has it established its maximum level of acceptable risk when insuring a borrower. Further, Cal-Mortgage does not effectively monitor its borrowers. Weaknesses in its monitoring include inconsistent methods to oversee borrowers, a lack of formal procedures for this oversight and insufficient supervision. Finally, because Cal-Mortgage does not have criteria for identifying problem borrowers that require executive management intervention, the director of OSHPD may not be fully aware of the risk present . . "*[8]

Of further concern was that the State-guaranteed loan insurance had been used for purposes not necessarily in keeping with the program's original legislative intent. For

[8] October 14, 1998 letter from Kurt R. Sjoberg, State Auditor, to Governor Wilson, President pro Tempore of the Senate, John Burton, and Speaker of the Assembly, Antonio Villaraigosa

example, Cal-Mortgage had insured loans for the acquisition of health care facilities and for working capital funds for borrowers in default, according to the report.[9]

To address these issues, the Auditor recommended a number of adjustments and procedures to the Cal-Mortgage Program, including:

1) Develop a more rigorous process to determine financial viability of applicants.
2) Establish guidelines and perform a more in-depth review of viability for repayment ability.
3) Obtain and analyze management letters and actions on the recommendations in the letters.
4) Define acceptable maximum level of insurance risk that may use a system of ranking or weighing the applicants' risk.
5) Consider elements such as public benefit, location, affected population and types of services rendered.
6) Fully implement its new process for earthquake insurance waivers. Eliminate FEMA (Federal Emergency Management Agency) funds from decision-making factors.
7) Require evidence of required proportions of Medi-Cal and Medicare patients.
8) Create a compliance tracking system with requirements of the regulatory agreement, including automatic contact to borrowers who are late in submitting required information.
9) Create a standard process of thoroughly reviewing financial statements.
10) Establish internal standards for ratio analysis with other borrower comparisons.
11) Create a formal review process to ensure consistent monitoring by project officers.

[9] October 1998 Report of the State Auditor

12) Continue training with new financial software and develop procedures on its proper use.
13) Establish procedures for timely and structured site visits.
14) Develop policies and procedures to properly monitor bankruptcy receivers appointed by the court.
15) Consistently review the management reports from portfolio databases to ensure accuracy, completion and maintenance.
16) Establish benchmarks or standard criteria for bringing a borrower's financial problems to OSHPD's attention.
17) Regularly bill defaulted borrowers for amounts paid on its behalf plus interest.
18) Ensure that financial statements on the Health Facility Construction Loan Insurance Fund include all assets and liabilities related to the defaults.[10]

Additionally, major changes in the health care delivery environment also appear to have affected the Cal-Mortgage Program in both its approach and its ability to fulfill its original purpose of providing greater access to health care (see next section, California's Changing Environment of Health Care Delivery). Among those changes are:

- Rapid consolidation of health care delivery services
- A growth in the use of managed care
- A greater number of uninsured Californians (23 percent statewide)
- A decreased demand for hospital beds
- A rise in the use of smaller health care facilities
- A growing need for greater emergency room capacity

Because of the considerations facing the health care industry and the Cal-Mortgage Program, the Joint Legislative Audit Committee held an informational public hearing to

examine the program, gain an understanding of its efforts, gauge its effectiveness in fulfilling its legislative intent and discuss solutions and/or necessary changes.

The hearing, held on January 20, 1999, in the State Capitol Building in Sacramento, featured discussion and comments from the following:

- Cal-Mortgage program executives and advisors,
- The California State Auditor
- Health care industry consultants
- Health care trade association representatives
- Cal-Mortgage program participants
- Labor union researchers and representatives.

[10] October 1998 Report of the State Auditor

Part One: California's Changing Health Care Environment:

Diminished Access to Health Care

In the 30 years since voters authorized the creation of Cal-Mortgage in an effort to guarantee reasonable access to health care for all Californians, the health care delivery environment has changed dramatically. While those changes have impacted health care availability for many Californians, they may also have affected Cal-Mortgage's ability to fulfill its original intent.

One of the more significant factors is the increased number of acquisitions and mergers among corporate health care providers, according to oral testimony from Service Employees International Union (SEIU) researchers.[11]

The SEIU, which represents the largest number of nurses and health care workers in the state, reported that the acquisition activities of large corporations -- such as Sutter Health, Catholic Health Care West and Tenet Health Care Corporation -- have resulted in the consolidation of needed health care services and, in general, have decreased the availability of health care.[12]

Fred Seavey, a researcher from Local 250 of the SEIU explained:

> *"Thirty years ago most hospitals were stand-alone facilities . . . a single facility in a community that was governed by a board of directors who lived in the surrounding community and had some organic link to the hospital itself. . . . . [Now] most of these hospitals have merged into massive multi billion dollar*

[11] Oral testimony from SEIU representatives, January 20, 1999

health care systems, such as Sutter Health or Catholic Health Care West. Catholic Health Care . . . has 46 facilities in California, $5 billion in assets, 45,000 employees. Sutter Health, one of its chief competitors in Northern California, has also gone through a flurry of mergers and acquisitions. . . . In 1996 Sutter Health acquired hospitals at the rate of one every six weeks. It's now a $3 billion company, [with] 27 hospitals, dozens of home health agencies, for-profit HMO, six medical research institutes, outpatient clinics. If it were a for-profit company, it would rank 160th among the Fortune 500.

Tenet Health Care Corporation, Columbia HCA, Adventist Health . . . have also gone through mergers and acquisitions. And many of the acquisition targets of these big systems have been the stand-alone hospitals that are the principal recipients of Cal-Mortgage.

As the massive systems buy up individual hospitals, we often see cutbacks, consolidations, and even closures of hospitals. . . . Sutter Health acquired Novato Community Hospital in Marin County in 1985 and pledged to keep the hospital as a full service hospital. Recently, it eliminated the maternity ward there, requiring pregnant mothers to travel to the next hospital in the county, which is also owned by Sutter Health, . . . a driving time of up to an hour. We recently had a case of one woman who gave birth on the freeway as she tried to make her way from what was formerly a full service hospital to Sutter's other hospital in the county."[13]

Access is further compromised when such mergers and acquisitions lead to decreased charity care, Seavey maintained.

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[12] ibid
[13] ibid

"[Both] Catholic Health Care west and Sutter provide substandard levels of charity care, which exacerbate California's huge problem of uninsured residents. Charity care, as you know, is the provision of services to uninsured and under-insured people who are poor. Sutter and Catholic Health Care West spent six-tenths and nine-tenths of 1% respectively of their net patient revenues on charity care in 1997. Meanwhile, the average non-profit hospital across the nations spent anywhere between three and five times as much, so roughly 3% or 3.1% of net patient revenues on charity care that year. Meanwhile, California – we have 23% of our population [with] no health insurance, roughly seven million people. The University of California system recently came out with a report that indicates that each month the number of uninsured in our state grows by 50,000 people. So this problem of [lack of] insurance and lack of access to health insurance is a huge problem, and these big systems aren't providing their fair share of charity care to the uninsured."

Further compounding the ability to maintain access to health care, a competitive climate has developed among the deliverers of health care, which has threatened the survival of community-based stand-alone hospitals, Seavey reported.

"The climate has gone increasingly predatory as well, which especially affects stand-alone hospitals who are at a disadvantage in competing with these massive systems. In San Francisco a stand-alone hospital that is covered by Cal-Mortgage is fighting for survival against Sutter Health. And, in fact, last year Sutter Health acquired another hospital in San Francisco, Davies Medical Center, and last week – well, Sutter has gone about, in order to capture more market share, recruiting the top doctors away from St. Luke's. So they've recruited the top 20 doctors who account for 24% of the paying patient admissions into the hospital. In other words, they take the patients away from from St. Luke's – and pass them into the Sutter system. Last week St. Luke's filed

suit against Sutter and Sutter's doctors' group on anti-trust grounds. I just wanted to emphasize sort of the nature of these predatory practices and what the stand-alone hospitals face. Sutter also faces FTC investigations for its doctors' group in San Francisco, as well as their proposed acquisition of Summit Medical Center in Oakland."[14]

Such mergers and acquisitions have apparently led to further complications, such as a decrease in oversight and local control, which exacerbates the problems of health care access, Seavey contended.

"Another consequence of these mergers and consolidations is oftentimes the elimination of local boards of directors. For example, in 1996 Sutter, which owns five hospitals in the Sacramento area, the three-county – Yolo, Sacramento, Placer County area – disbanded the boards of directors at the five hospitals and replaced [them] with a single corporate board. CHW did something similar in San Francisco, eliminating again local boards of directors and replacing them with a single board of directors. And . . . this . . . moves and transfers power away from the local hospitals to entities and people who are more distanced from the local hospitals."[15]

These trends appear to have additionally diminished access to health care in other communities and may have been a factor in some of Cal-Mortgage's defaults. In Los Angeles, for example, the for-profit Tenet Health Care Corporation acquired the stand-alone Queen of Angels Hospital, a hospital that provided emergency care for a number of uninsured patients. Emergency care is now limited. Mike Gipson from SEIU's local 399 elaborated during his testimony.

[14] ibid

"Queen of Angels is located in the inner city, serving the low income, primarily immigrant communities. In 1989 the hospital faced a serious financial crisis, potentially closure. Cal-Mortgage insured a $21 million loan to the hospital. The state bailed out the hospital and kept it afloat, even gained the financial stability of the hospital. Unfortunately, the overwhelming amount of investment in the hospital did not bring with it a guarantee of increasing community access to care at the hospital. In fact, access to care was threatened by the hospital takeover by Tenet Health Care Corporation last year. Tenet was unwilling to guarantee that [the] hospital would continue to serve the poor and that health services, such as emergency rooms would be maintained. Only after overwhelming community outcry did Tenet agree to [minimal] protection. Even with these provisions, Tenet is free to close [the] hospital's emergency rooms and obstetric units five years after the purchase, and the rest of the hospital services can close at any time."[16]

Queen of Angels is just one example of a growing statewide problem. Gipson characterized the broader scope in which health care is being compromised and the detrimental results:

"As consolidations have increased, corporations' decisions are designed to reduce costs, [and] have threatened community access to health care. A common result of hospital mergers has been closing the emergency rooms. A recent study commissioned by the National Health Foundation found a widespread shortage of emergency room capacities in L.A. County. In 1995 the demand for E.R. visits exceeded supplies by nearly half a million visits. By the year 2005 the best case scenario predicts that the demand will exceed supplies by nearly 700,000

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[15] ibid
[16] ibid

emergency visits. The worst case scenario predicts a shortage of over 1.3 million visits."[17]

In addition to Queen of Angels, other Cal-Mortgage recipients have fallen victim to increased competition and consolidation. The stand-alone hospital called Los Medanos Health Care Corporation wound up in bankruptcy and eventually closed its doors. Al Prince, Chairman of the Los Medanos Board of Directors testified:

"Los Medanos is located in the city of Pittsburg, California. About three and a half miles away is the Sutter facility. About three miles away is a Kaiser facility. So when you look at the market and you have a stand-alone facility already in trouble against two of the biggest competitors in the industry, you have a tough road to hoe.

I must also share with you I serve on the board of directors of two other stand-alone facilities in the same county, and it is a challenge. It's going to be very difficult, even though both are excellently run and have good financial reserves, not to look at the reality of what's happening to health care and stay stand-alone that much longer.

So when you go into this market and you go into the environment and you go back to 1994, which is what's happening here, there are a lot of factors that come into play."[18]

[17] ibid
[18] Oral testimony of Al Prince, January 20, 1999

The Los Medanos closure, in addition to diminishing health care access, may have had additional demoralizing ramifications on the community. Prince discussed this during his testimony:

> *"In terms of our community, Los Medanos used to be the largest employer in Pittsburg. It was a source of pride for that community. Up until a year and a half ago, before they disbanded, the volunteers of that area – they'd still meet every couple months. There'd be 150 people there. They were committed to that hospital, its growth and its direction. But, of course, people don't make decisions anymore in health care. The employers do. Big companies do. And given the realities of the market, what happened happened. It was a tremendous source of community and public pride that will never come back.*
>
> *There's probably not a day we don't go through the community where someone comes up and corners us and wants to know when the place is going to reopen, when are they going to have their hospital back – because it certainly was a public asset. It's gone to them forever."*[19]

Similar circumstances threaten other healthcare districts, according to Vic Biswell, of the Association of California Healthcare Districts (ACHD), which represents the 73 healthcare districts of California (districts often operate small and rural hospitals):

> *"It's heresy for a person from a hospital association to talk about this, but many of those small hospitals out there may not function in the future as hospitals."*[20]

[19] ibid
[20] Oral testimony of Vic Biswell, January 20, 1999

ACHD's Chief Financial Officer, Jim Giannini, elaborated in a post-hearing interview with the JLAC committee consultant.

> *"Many face fierce competition with these affiliations and associations and managed care. For example, we have a little hospital in a bedroom community where people commute into the city for work. This hospital is confronted with people using Catholic Healthcare West or other [conglomerates] that they may have to use because of their employers.*
>
> *Some of these district hospitals began as rural hospitals, but the area became urbanized. As industry moves in, one of the big [health care corporations also] moves in and gets the employers to sign up on their health plan. If our hospital is not on [the employer's] provider list, the community goes to [another provider]."*[21]

Further complicating matters is the rising number of uninsured Californians, which increases the burden on hospitals such as the District Hospitals, according to Giannini:

> *"Our hospitals carry a disproportionate share of [uninsured and charity care]. Where do the indigent or homeless people go? What about the uninsured? They can't go to [a deliverer like] Kaiser, where you have to be a member. We're not going to refuse them."*[22]

The increased acquisition activities further diminish quality of health care as well, according to Biswell. In a post-hearing interview with JLAC, he said,

[21] JLAC telephone interview with Jim Giannini, April 14, 1999
[22] ibid

"A community-based delivery system is the resource that takes care of the community as well as the underserved and uninsured, and it's important that the people there have a sense of ownership. They don't have ownership of this system of managed care and impersonalized health care, where decision making is made from afar about whether you need care or not. When an HMO (health maintenance organization) comes in from outside and buys up the practices of five of the eight local physicians, the HMO then owns those physicians and can dictate where they send their patients. With the federal cutbacks, without the resources, . . . more control will go outside the community."[23]

[23] JLAC telephone interview with Vic Biswell, April 15, 1999

Cal-Mortgage Adaptation to Industry-Wide Changes

Although OSHPD acknowledged some of the general changes affecting health care delivery and the increased unmet needs, it did not identify a comprehensive approach for addressing the problem of decreased access. It simply made the general statement,

> *"Cal-Mortgage must continue to complement [other State efforts] by helping to assure that there are adequate facilities in which these programs and services can operate."*[24]

However, the Cal-Mortgage program has responded to industry-wide changes by shifting its support away from hospitals and instead toward outpatient facilities, according to testimony from OSHPD's Dr. David Werdeger. Now, the portfolio of state-backed loan insurance recipients may contain providers such as primary care clinics, blood banks, substance abuse treatment facilities, group homes for emotionally disturbed children, AIDS treatment centers and multi-level residential facilities for the elderly.[25]

> *"In June 1998, of the 206 insured projects, 19 percent were hospitals, 25 percent were clinics and 44 percent addressed special needs populations.*[26]

> *Hospitals were at one point 38 percent of our portfolio … primary care clinics were 18 percent .. . Multilevel facilities have increased from 6 percent . . ."*[27]

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[24] 1995 Cal-Mortgage State Plan
[25] Oral testimony of David Werdeger, January 20, 1999
[26] February 26, 1999 memorandum from Dennis Fenwick to JLAC consultant Maria Armoudian
[27] Oral testimony of Dennis Fenwick, January 20, 1999

This shift in emphasis appears to reactively address particular health needs. For example, the 1995 Cal-Mortgage State Plan addressed the needs of people with chronic mental illnesses by supporting community-based facilities.[28]

However, a host of other needs and the larger context of diminished access to health care appear to go unaddressed and may lack Agency support.

In order to be effective in its mission of increasing access to health care, California Health and Safety Codes require the OSHPD to perform a series of tasks to determine what the needs are. Code section 129020 explains:

> *"The office shall make an inventory of all existing health facilities and shall survey the need for construction, improvement and expansion of public and nonprofit health facilities and on the basis of that inventory and survey, shall develop a state plan. . . . The health facility construction loan insurance program shall provide for health facility distribution throughout the state in a manner that will make all types of health facility services reasonably accessible to all persons in the state according to the state plan."*[29]

The State Auditor, however, maintained that administrators are not adequately qualifying or quantifying need.[30]

Until 1987, Cal-Mortgage relied on a federal program called the Certificate of Need to analyze and assess the community's health care needs. Throughout the late 1970s and early 1980s, OSHPD required those health care operations that applied for Cal-Mortgage

[28] February 26, 1999 memorandum from Fenwick to Armoudian
[29] California Health and Safety Code, Section 129020
[30] October 1998 report of the State Auditor

loan insurance to obtain certification under the federal guidelines in order to qualify for the program.

But the Certificate of Need was dissolved in 1987, and OSHPD and Cal-Mortgage have failed to replace it with a comparable approach.[31]

During the January 20 hearing, several Legislators expressed concern that OSHPD lacked both a comprehensive needs assessment procedure and an overall coordinated approach. Cal-Mortgage Deputy Director Dennis Fenwick, however, said that this type of comprehensive approach

> *"to needs assessment is not likely to be successful. Data are simply not available to accurately assess the need for services . . . for each and every California community. Even if such data were available, a strong argument has been made that community needs are best determined by the local community."*[32]

Rather than using comprehensive data, it appears that Cal-Mortgage staff are only proactive on a case-by-case basis in determining whether the

> *"proposed project is truly needed in the community. . .*
> *Cal-Mortgage does not assess . . . [the] need for healthcare providers . . . in each and every community throughout California . . . nor could it feasibly do so."*[33]

In fact, Cal-Mortgage maintained that most need-related decisions are *"best made at the local level by the people involved, by the health facilities involved."*[34]

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[31] Oral testimony of Kurt Sjoberg and John Baier, California Bureau of State Audits, January 20, 1999
[32] February 26, 1999 memorandum from Fenwick to Armoudian

Rather than using a comprehensive needs assessment, Cal-Mortgage administrators have primarily relied on

> *"so-called feasibility consultants that have been engaged by the applicant.* [*The consultants*] *admittedly . . . are biased in favor of their client and will try and put a best face forward."*[35]

Unfortunately, many of the "*so-called feasibility studies*" were deemed inadequate by the State Auditor. John Baier, who supervised the audit, elaborated:

> *"We didn't see the depth of review that we might expect . . . For example, the viability of a project -- to what degree or extent will this assist in the health care delivery in the area in which this facility is being constructed or improved or expanded? To what degree will that result in the ability of that entity to serve that community and to do so viably? We saw that there was, in our view, too much recognition of financial viability studies done by individuals who are hired by the entity.*[36]

The Cal-Mortgage staff does, however, use additional methods to *"focus the program on high priority needs of the State,"* according to Deputy Director Fenwick. Such methods include the following:

- Coordination with other governmental agencies that address health care needs.
- Coordination with healthcare industry associations and advocacy groups in an effort to understand membership needs

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[33] ibid
[34] Oral testimony of David Werdeger, January 20, 1999
[35] Oral testimony of David Werdeger, January 20, 1999
[36] Oral testimony of John Baier, January 20, 1999

- Attendance at periodic conferences regarding healthcare developments and the future of healthcare delivery
- Attendance at public hearings

Additionally, project officers analyze applications with criteria like:

- demographics
- community economics
- demand for services
- special needs of the community
- availability of services[37]

Officers compare the obtained data to information at OSHPD or other agencies, such as the Health and Human Services Agency, according to Fenwick. Finally, the officer visits the site to gather information directly from the affected community.[38]

[37] February 26, 1999 memorandum from Fenwick to Armoudian
[38] ibid

Cal-Mortgage's Approach in the Competitive Health Care Environment

In its 1995 State Plan, Cal-Mortgage acknowledged the increased pressure on individual hospitals and hospital-based systems due to managed care activities, increased competition and increased focus on financial incentives. It did not, however, propose specific solutions to combat the detrimental effects of these factors.[39] Instead, Cal-Mortgage encourages applicants to

> *"actively explore and consider affiliation" . . .* justified because *"those [facilities]. . . which are not part of a network participating in managed care are the ones . . . facing the most significant financial difficulties.. . . . it is important for healthcare providers .. . to have networking relationships . . . for purposes of managed care contracting."*[40]

Both legislators and witnesses expressed concern that Cal-Mortgage loan insurance may be being used by health care facilities to complete capital improvements immediately prior to being acquired by larger HMOs or corporations, further compromising access to health care. This appeared to be the case in at least 14 instances of Cal-Mortgage insurance. JLAC Chairman Wildman elaborated,

> *"We've identified a number of hospitals acquired subsequent to [receiving] loan [insurance], and we don't know what the impact on the community is of those acquisitions. I have personal experience with the Queen of Angels Hospital in my district. It's in a very highly impacted, economically difficult area of Los Angeles. Millions of dollars [in Cal-Mortgage insured] loans went to Queen of*

[39] 1995 Cal-Mortgage State Plan
[40] February 26, 1999 memorandum from Fenwick to Armoudian

Angels, which was then acquired by Tenet just last year. Tenet has only made a commitment to keep the emergency room open for five years. This is a hospital that had a huge portion of its operating revenue devoted to charity care. Certainly there are some guarantees, but the community is very uncomfortable about what they are going to mean in the long-term."[41]

Werdeger responded.

" *. . . when they get purchased, which is not under our control, but if they decided to get purchased by, in this case, a for-profit entity, Tenet, . . . the Attorney General is required to see what the community benefit is owing by that hospital, by Queen of Angels, and that they provide it after they have been purchased by a for-profit hospital."*[42]

[41]Oral statement by JLAC Chairman, Scott Wildman, January 20, 1999
[42] Oral testimony of Werdeger, January 20, 1999

Continued Need for the Cal-Mortgage Program

Despite the flaws in Cal-Mortgage's needs assessment and determination process, the program has provided a valuable service to a number of health care providers and was often used as a *"last resort,"* according to several witnesses.

During the January 20 hearing, Cal-Mortgage articulated its priorities, which included the following:

> *"Projects in medically under-served areas, projects that serve medically under-served populations, . . . promote access to primary care services . . . provide services that allow individuals with special needs to function optimally in the community-based environment and avoid the need for institutional placement, for example, the frail elderly, children with developmental disabilities. We give priority to projects that provide innovative solutions to health care delivery problems, for example, efficient use of networks in rural areas or integrated services for persons with AIDS and HIV."*[43]

Several health care providers relied on Cal-Mortgage for their survival, witnesses testified.

Vic Biswell, of the Association of California Healthcare Districts (ACHD), testified that only eight of the 46 districts operating acute care hospitals can get private market funding. Eighteen of those hospitals can qualify for Cal-Mortgage, but the rest are *"hanging out to dry,"* he said.

[43] Oral testimony of David Werdeger, January 20, 1999

The 18 qualifying for Cal-Mortgage, while "*well-managed with a positive bottom line,*" cannot qualify in the private market. Due to their small size, they are not rated by the ratings agencies, and consequently they must rely on Cal-Mortgage, testified Biswell.

> *"If a program like Cal-Mortgage . . . [does] not exist or [is] unable to assist the majority of hospitals in California, the majority of small and rural hospitals, you will lose the rural infrastructure throughout California. There is no place to turn."*[44]

Similarly, Lytton Gardens, a low-income senior facility, "*would not exist*" without Cal-Mortgage, according to Vera Goupille, Lytton's President and CEO. She said:

> *"Cal-Mortgage insures our skilled nursing facility, which now has 145 beds. If we didn't have such a program in California, there would not be a Lytton Gardens, and there would not be the thousands that have been served, provided with the sense of security when they move in. And although they're poor, they can be taken care of for the rest of their lives, even though they might not have the money to move into the Forum or the Hamilton, which now rate at $1 million to get in."*[45]

The program provides an invaluable service, said Goupille:

> *"On any given day we serve roughly 550 people [with an] average income [of]$10,000. Many times we have at least a half dozen people over 100 with no other surviving relatives. They put money away and planned for the future but never expected to live so long. So we believe that we provide something*

[44] Oral testimony of Vic Biswell, January 20, 1999
[45] Oral testimony of Vera Goupille, January 20, 1999

incredibly valuable. There are only one or two other facilities like us in Northern California that include housing, assisted living, and skilled nursing as part of the campus.

Most recently, when we opened up the new facility, which has 50 units, we had over 600 applications and actually had to get restraining orders for some of those on the waiting list in their desperation to get in. We do believe that we are . . . perhaps irreplaceable."[46]

Today, many health facilities are facing new financial burdens due in part to State requirements for extensive retrofitting and in part to decreased funding from the federal government. *"In the absence of funding . . . those hospitals and clinics may not be seismically safe and, therefore, have to close,"* said Michael Dimmitt of the California Health Care Association.[47]

These closures would further endanger already scarce access to emergency rooms, according to Biswell, who added:

"You cannot have an emergency room or an emergency facility for stabilization purposes unless it's attached to an acute care hospital. So in many of our isolated areas you have to maintain an acute care hospital."[48]

[46] Oral testimony of Vera Goupille, January 20, 1999
[47] Oral testimony of Vic Biswell and Michael Dimmitt, January 20, 1999
[48] ibid

Part Two: Cal-Mortgage Prerequisite and Risk

While fulfilling on its charge to guarantee reasonable health access for all Californians, Cal-Mortgage has one parameter -- to provide its service *"without cost to the state."*

During its 30 years of existence, Cal-Mortgage has insured approximately $4 billion in loans to more than 400 health care facilities, according to testimony from Werdeger. And from an initial appropriation of $1 million, the program has generated reserves of approximately $130 million.[49]

With its guiding principles that included a project's financial feasibility, the program appears to have been highly successful in protecting the State's reserves until 1992, according to Werdeger.[50]

However, beginning in 1992, a series of seven borrowers defaulted on their loans, which were backed by the State's full faith and credit, consequently risking the State's resources. Their circumstances are described below.

[49] Oral testimony of David Werdeger, January 20, 1999
[50] ibid

The Defaults

I. Triad Healthcare Corporation

The most severe default on a Cal-Mortgage-backed loan was that of Triad Healthcare Corporation (Triad). In addition to facing a $182 million debt, the OSHPD and the State of California have also been entangled in litigation due to a conflict of interest.[51]

Triad was a newly-formed non-profit corporation that approached Cal-Mortgage to insure the bonds needed to purchase two hospitals, Sherman Oaks and West Valley, from Nu-Med, a for-profit company.

However, Stuart Marylander, the man who formed the non-profit Triad, was simultaneously an officer and director of the for-profit Nu-Med. He was therefore on both the buyer's side and the seller's side. Marylander formed Triad with a local businessman and became its President and CEO. Marylander was also a Nu-Med officer when he appeared before Cal-Mortgage's Advisory Loan Committee on Triad's behalf.

Triad retained the investment firm Goldman Sachs & Company (GS), despite the fact that GS was simultaneously retained by Nu-Med, from which it would receive its commission. Furthermore, the law firm Musick, Peeler & Garrett (MPG) was counsel to both the buyer and the seller, although it only represented the buyer in the actual transaction. (MPG never resigned as counsel for Nu-Med).

Triad agreed to purchase the two hospitals for $135 million using Certificates of Participation bonds, and applied for Cal-Mortgage loan insurance to back the bonds.

Upon review, the Cal-Mortgage project officer recommended against providing the insurance. But despite her recommendation, Cal-Mortgage agreed to guarantee the bonds. Considerable controversy arose around the conflicts of interest, leading the Attorney General to step in and review the transaction.

Although it could have withdrawn its commitment any time prior to the transaction's closing, Cal-Mortgage continued to back the bonds. In July 1993, Triad defaulted on its bond payment obligation. It filed for bankruptcy the following February.

OSHPD filed actions against Goldman, Sachs & Company (GS), Triad's investment banker, for failing to disclose its conflict of interest and its receipt of a $1.5 million commission from the seller (Nu-Med). The State agency claimed that if it had known that GS was representing both the buyer and the seller, it would not have agreed to insure the bonds. The parties settled the suit, with GS promising to assist in refinancing the outstanding bonds and pay $28.5 million to OSHPD.[52]

Cal-Mortgage also filed suit against Marylander, Triad's former President and Chief Executive Officer; Valuation Counselors, the company that appraised the hospital; Medical Pathways, the company that prepared a feasibility study; and Triad's counsel, Musick, Peeler & Garrett.[53]

In the Musick, Peeler & Garrett suit, the Superior court ruled in favor of the defendant, stating that OSHPD "*failed to meet its burden*" and found there was no "*triable issue of material fact*" or "*triable issue as to whether Statewide [OSHPD]*

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[51] October 1998 Report of the State Auditor
[52] January 13, 1999 JLAC telephone interview with Deputy Attorney General Shelleyanne Chang
[53] Respondents' Brief, Court of Appeal of the State of California

justifiably relied upon Marylander's alleged misrepresentations."[54] The court added that OSHPD

> *was "in the business of evaluating loan transactions . . . and was charged with doing so by statute. . . . Statewide's independent investigation provided it with a full awareness of the possibility that Triad was paying too much."*[55]

The case is currently in Appeals Court.

Cal-Mortgage has paid over $35 million on Triad's debt.[56] In the end, it appears that Triad will cost the State approximately $200 million.[57]

II. Los Medanos Health Care Corporation

In another large default case, the insured, Los Medanos Health Care Corporation, filed for bankruptcy and defaulted on bonds totaling $11.1 million, which it had issued to renovate, expand and pay off existing debt.

From as early as 1990, signals indicating financial trouble were present, according to Al Prince, the current Chairman of Los Medanos's Board of Directors.

> *"I looked at the financial statements from 1990, on the basis of which this loan was initially made, which got the district in trouble. No one in their right mind*

[54] October 2, 1997 Ruling of Honorable Ronald E. Cappai, Superior Court of California, County of Los Angeles
[55] ibid
[56] October 1998 Report of the State Auditor
[57] JLAC Telephone interview with Bureau of State Audits

would approve a loan like that. . . . Had there been ongoing monitoring – and maybe aggressive monitoring, you would have had less problems."[58]

The district hospital's finances deteriorated further and Los Medanos filed for bankruptcy when its problems were further exacerbated, according to Prince.

"When I came on the board in December of '94, the court-appointed receiver, John Connolly, had been there about ten months. He was . . . highly recommended by Cal-Mortgage, who was the biggest debtor at that point and was telling the board, 'Look, you need to get your act together . . . . We want to bring this turn-around guy, this expert, to come in and help you try to put this thing back on track.' One of the first actions [Connolly] did was close the facility. I've been told repeatedly by experts across the country that the worst thing that could have happened to that hospital was its closure. It's the last thing you do to a community asset. You force all your employees to go somewhere else; you force your doctors to negotiate new business with different hospitals, different entities, and you take all these people in a community that love that place and support it, and you force them to go somewhere else. And that's what happened. In April of 1994, over 500 people lost their jobs. Hundreds of doctors and thousands and thousands of people were forced to go somewhere else. That was the worst decision that could have ever been made, but it was made by the receiver in conjunction with the board because the receiver, as the expert, as the turn-around guy, said this is the best thing we can do under the circumstances. Later we learned that Mr. Connolly had no experience in health administration. He had never worked in a clinic or a hospital . . . . He didn't know what to do in ordinary circumstances in terms of running a facility, much less what to do with a facility like this one that had so many problems. Their market share was eroding; they were paying far more than the market could provide. They negotiated a number

[58] Oral testimony of Al Prince, January 20, 1999

of very poor contracts with different organizations. You really needed someone like Stu Jed, who also is a consultant with Cal-Mortgage, to step in and be the bad guy. . . Stu . . . thought he was going to go in to Los Medanos with Mr. Connolly, Mr. Connolly being the real estate person and Stu being the turn-around expert, and was advised by Cal-Mortgage that they had changed their mind and decided to bring in Mr. Connolly instead. I wish that they . . . would have had someone in there with the backing of the state to be able to help the board and community make the tough decisions – to make the changes." [59]

Cal-Mortgage paid $9.2 million to retire Los Medanos's debt, and the district hospital, after closing its doors, rented its facilities to the county.

III. Health Care Delivery Services

In another case, Health Care Delivery Services (HCDS), a planned adolescent treatment facility program faced a series of circumstances that led to its failure. HCDS experienced delays, a decreased need for its services, a series of on-site incidents that led to the withdrawal of the Los Angeles County Department of Children and Family Services and an investigation by the Department of Social Services.[60]

In the end, Cal-Mortgage foreclosed on its property and paid $1.85 million on its debt.[61] The foreclosure, according to Fenwick, was a way of *"resolving these problems without resorting to bankruptcy. . . there was never a legal paper filed in court."*[62]

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[59] ibid
[60] January 19, 1999 Written Testimony of Roy Rodriguez, Chairman of the Board of Directors of Health Care Delivery Services
[61] October 1998 Report of the State Auditor
[62] Oral testimony of Dennis Fenwick, January 20, 1999

IV. *Other Defaults*

One of the other defaulting borrowers, Community Adult Care Centers of America (CACCA), has disbanded its operations. Cal-Mortgage paid $4.6 million of its debt. The remaining three defaulters -- Villa View Community Hospital, Lytton Gardens Health Care Center and the Third Floor (drug rehabilitation) -- are all still in operation. Villa View and Third Floor are making at least partial debt-service payments, and Lytton Gardens has had four years of consecutive positive income. Total Cal-Mortgage payments for all three reach approximately $2 million.[63]

When Lytton Gardens defaulted and *"dipped into the insurance fund to the tune of $409,000,"* Cal-Mortgage intervened, according to Vera Goupille, Lytton Garden's President and CEO. She explained the working approach during her oral testimony.

> *"[Cal-Mortgage] pressured the board to bring in . . . seasoned management – and they stood by us. They did propose we use consultants, and we asked not to use them. . . . [The consultants] would have cost us in the neighborhood of another $30,000 to $50,000 and, I think, slowed us down.*
>
> *[Cal-Mortgage] were open-minded about the workout plan. Most of the $409,000 was actually put into building additional capacity because we were, at that time, licensed for 130 beds, the break-even point. So there wasn't really an opportunity to ever make up on good months if there was census on the low months. Sometimes you have to invest in order to dig yourselves out of the hole further. And even though it might feel riskier in the short term, the result was that six weeks after we opened those [additional] beds, we broke even, and we will*

[63] October 1998 Report of the State Auditor

close our fiscal year March 31st with four consecutive years of positive net income.[64]

[64] Oral testimony of Vera Goupille, January 20, 1999

Cal-Mortgage's Procedures that May Have Allowed for the Defaults

In his testimony, Sjoberg summarized a series of observations made during the Bureau of State Audit's review of Cal-Mortgage's pre and post insurance procedures that may have contributed to the series of defaults.

> *"We found problems in both [the pre and post insurance procedures]. From the before side, the application side, we saw inconsistency. We didn't see the depth of review that we might expect to assure that risks are being minimized. For example, the viability of a project -- to what degree will [it] assist in the health care delivery? There was . . . too much recognition of [and reliance on] financial viability studies done by individuals hired by the entity seeking the loan . . .[and] a lack of benchmark or consistency of the process of screening efforts."*[65]

Sjoberg also noted that Cal-Mortgage didn't use objective scoring criteria similar to those private sector insurers might use, such as

> *"a score of a certain number of points that a potential borrower would have to achieve before being deemed to be sufficiently unrisky.*
> *While there could be exception if there is an overwhelming need for this particular service in the community . . . discretion [would rest] at the very highest levels of Cal-Mortgage and OSHPD."*[66]

In the case of overwhelming need then,

[65] Oral testimony of State Auditor, Kurt Sjoberg, January 20, 1999
[66] ibid

> *"it would be appropriate to manage and monitor that higher risk borrower throughout the life to assist as needed -- early if they have problems or setbacks and to make them successful."* [67]

JLAC members expressed concern about the loan application process, particularly when they learned that the Loan Advisory Committee had never denied an application.: *"During the four years that I have been on [the Cal-Mortgage Loan Advisory Insurance Committee (ALIC)], I don't believe we have denied, as a group, any,"* said ALIC Advisor, Mort Rafael. *"We have delayed a couple . . . they were contingent approvals,"* added ALIC member Robert Taylor.[68]

Sjoberg reiterated the problems that Cal-Mortgage experienced in the post approval stages as well: *"Once they are borrower[s] and we have insured their borrowing, we need to be vigorous in terms of monitoring. And we found inconsistency there as well."*

Particularly, Sjoberg noted that insurance recipients were inconsistently compliant when submitting pertinent data that helped to assess fiscal viability. Data such as quarterly fiscal state financial statements, annual audited statements, management letters and other documents that describe the facilities' financial health were irregularly submitted, which created difficulty in making "*reasonable monitoring decisions."*

> *"If we're going to set those criteria as required, we need to make sure that everybody sends those in. We found gaps in that process. We also found that site visits were scattered. Some were made irregularly, some not for five years."*[69]

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[67] Oral testimony of State Auditor, Kurt Sjoberg, January 20, 1999
[68] Oral testimony of Mort Raphael and Robert Taylor, January 20, 1999
[69] Oral testimony of Kurt Sjoberg, January 20, 1999

Further, Cal-Mortgage was without a comprehensive *"watchlist"* or similar database that would create a type of *"early warning system,"* similar to those bond raters use to help identify borrowers who may need greater attention. Sjoberg explained:

> *"[Bond raters] track the same kinds of data for a state or local municipality issuing debt. And early on, if some of the indicators begin to go south on them, they just flag that entity. They don't pull the rating, but they realize that there's a watch list. . . . Then you would have the ability to recognize that we might have 10% of our portfolio that needs greater attention, more vigor. And then we focus our attention – site visits, more intensive monitoring, monthly monitoring and all the rest – to those that are on our early warning lists."*[70]

While Cal-Mortgage may have missed the early warning signs at Los Medanos, some witnesses, such as Gerald Dingavan of Southern California Presbyterian Homes, attested that the program was too vigorous:

> *"In fact, our opinion is that they're too rigorous. The current program that we have with our own rating and with NBIA insurance has left actually a less rigorous process than Cal-Mortgage has . . .We left Cal-Mortgage, and why did we leave Cal-Mortgage? Actually, the reason we left Cal-Mortgage was not primarily because of the lower cost. We actually left the program because we felt that the oversight was too rigorous, and what we wanted to do was continue to expand our health care program in California."*[71]

[70] ibid
[71] Oral testimony of Gerald Dingavan, January 20, 1999

Catching problems early enough for intervention is particularly a challenge, according to one turnaround consultant, Stuart Jed.

> *"At one point in my career [when] I had 21 hospitals reporting to me, I would get their financial statements 30 days after the close of their fiscal month. That wasn't enough time to react. And by the time I got to review it, it was 45 days. When you talk about financial audits done on an institution, you're lucky if you get an audit out 120 days after the close of the fiscal year. You're lucky if you get a management letter out 180 days after the close of the fiscal year. That might not be enough time. And, unfortunately, management is not going to bring [the problem] to their venture capitalist or Cal-Mortgage."*[72]

Jed suggested that Cal-Mortgage secure a place on each Board of Directors.

> *"If they're sitting on the board, they will know what's going on, and I think that ought to be considered."*[73]

[72] Oral testimony of Stuart Jed, January 20, 1999
[73] ibid

Crisis and the Use of Turnaround Specialists and Receivers

Another concern articulated during the hearing was the selection of turnaround consultants, specialists and receivers who are retained in the case of crisis. At Los Medanos, the receiver's recommendation to close the facility was considered the fatal action for the hospital, according to Board Chairman Prince (see earlier section on Los Medanos default). This led Prince to ask for specific attention to receivers and consultants.

> *"If there [is] one thing I'd want to add to that, [it's] the whole issue of receivers. If you're going to bring people in – make sure there's some sort of review process and [that they] know what they're doing – they have the experience, they have their expertise. How someone could earn $10,000 to $30,000 a month on this job – God only knows. I don't think any of us will ever know, but it should never happen again. . . . Mr. Connolly . . .[made] a minimum of $10,000 to $30,000 a month not knowing what he's doing."* [74]

In fact, turnaround specialist Stuart Jed said he had made recommendations to Los Medanos but was ignored.

> *"At the request of Los Medanos' attorney back in March of 1993 I was called into their board to speak, and we did that at no fee. And during that meeting I sat down and I said, 'You guys are in big trouble. You have about a million dollars a month more in payroll than you need. You have to restructure all your hospital-based physician contracts. You have trouble with your other contracts.' And this*

[74] Oral testimony of Al Prince, January 20, 1999

is just looking at their financial statements for about 15 minutes. We also recommended at that time that periodically they should have closed down a couple of programs, get the place stronger, restructure. No one was interested. The board of directors thanked me very much and said don't let the door hit you in the back of your legs as you leave. They weren't interested in listening. As a matter of fact, I think, in six months they went into bankruptcy."[75]

Assemblymember Tom Torlakson expressed further concern over the Los Medanos appointed receiver's advice and consequent actions.

"For months and months . . . there didn't seem to be a plan as to how to get the assets brought back into the health care community as a viable entity and . . . a lot of channels were tried or paths taken that proved fruitless. . . . It seemed also that there was not any oversight and . . . the receiver receives somewhere close to $300,000 or half million dollars in that process. They ultimately unraveled about a $25 to $30 million bankruptcy problem and five years of the hospital facility in the 100-bed adult care facility being in limbo. . . The hospital facility [was] actually empty while trying to figure out how to get out of bankruptcy.[76]

Jed discussed some various approaches that he had taken to turn around health care operations that faced financial crisis.

"We've had to change the board of directors; we've had to change management. We've had to terminate contractors that were providing construction to the facility because they were ripping off the facility. . . . The thing that has surprised

[75] Oral testimony of Stuart Jed, January 20, 1999
[76]Oral statement of Assemblymember Tom Torlakson, January 20, 1999

me in the turnarounds that we have done, is the unbelievable amount of negotiation that you can do. In one place we negotiated with the IRS. I never thought the IRS negotiated. And in this particular place the institution owed the IRS $1.4 million for failure to pay employee taxes. And on top of that they had penalties and interest and so it was really skyrocketing. We went in and sat down with the IRS, and they negotiated. That surprised me.[77]

[77] Oral testimony of Stuart Jed, January 20, 1999

Part Three: Cal-Mortgage's Adjustments Based on State Aduititor's Recommendations

Cal-Mortgage has already begun adjusting its program based on the State Auditor's recommendations, according to Fenwick.

> "*Concerning the application review and portfolio monitoring systems, we made important progress in three areas.*
>
> - *We have improved communications with other state departments. We now meet periodically with staff of the Department of Health Services, Department of Alcohol and Drug programs, Department of Social Services, DHSS in Region 9, and others. These regular meetings have proved to be an extremely valuable way for Cal-Mortgage to keep on top of the latest developments which might affect applicants or insured projects.*
> - *We have introduced two bills that give us additional authority to intervene in various projects.*
> - *Third, we have introduced computerized systems, two of them, to improve our financial analysis of applications and to enhance our monitoring of our portfolio.*
>
> *The office has identified 26 tasks [altogether] . . . Ten of those have already been completed. Most significant is the automatic project tracking system in use by all project officers. The data in the system is routinely checked for accuracy. Another is that staff are receiving additional training on automated financial analysis systems, which is used both in the analysis of new applications and in the project monitoring process. We are also in the process of formalizing the site visits that were previously mentioned. A system has been implemented to bill defaulted projects for debt service payments made on their behalf by Cal-Mortgage. All the detail of the assets and liabilities of defaulted projects is now*

routinely reported to OSHPD's accounting staff for inclusion in the financial statements of our health facility construction loan insurance fund from which we make the payments.

Work is progressing on the remaining tasks. By summer we plan to have completed the following remaining tasks -- written guidelines to help stabilize project officers' review of loan applications will be developed. These guidelines will include provisions for most effective use of our automated financial analysis software, which has been recently implemented by the program. The software will be modified to allow comparisons of applicants and insured projects with similar types of facilities to help in assessing the financial forecast and in monitoring ongoing performance.

Written guidelines will [also] be developed to define circumstances under which Cal-Mortgage will insure working capital loans.

A uniform protocol for assessing project officer performance will be developed and implemented. This protocol will address the project officer's effective use of these automated project tracking and financial analysis systems. The performance will also look at the timely and accurate input of project data into these systems by the contract officers, adherence to policies for regular site visits that were mentioned, and thoughtful oversight by those project officers relative to their monitoring of the borrower.

And a final example – the office will review risk assessment guidelines used by private lenders and insurers and determine their applicability to Cal-Mortgage.

The task of developing more explicit risk assessment criteria and defining maximum acceptable risk while preserving the flexibility to address real community needs will be the major challenge.

We have restructured [the advisory loan insurance committee] membership to provide expertise in current health care industry trends, the bond market and insurance practices, health facility management, and assessment of community needs. We have improved the preparation of staff analysis of application proposals, provide more thorough information to the committee, to Dr. Werdeger, about the financial feasibility, the security we're going to receive and the community needs for each project."[78]

[78] Oral testimony of Dennis Fenwick, January 20, 1999

Part Four: JLAC Recommendations

The JLAC makes the following recommendations:

1) **The Legislature should add language to existing codes, requiring OSHPD to perform the following tasks and articulate the results in its biennial state plan:**
    - ♦ Analyze Cal-Mortgage's success in meeting is mission.
    - ♦ Perform a thorough biennial statewide inventory of health facilities and health facility need, including the average percentage of hospital beds and vacancies.
    - ♦ Assess the program's efforts and effectiveness in placing borrowers in areas that have an urgent need for health services.
    - ♦ Provide statistics showing borrowers' compliance with community service obligation requirements.
    - ♦ Assess the current and future health care environment and the program's plan to meet the challenges of the projected changes in the health care environment, specifically with regard to meeting its mission.
    - ♦ Develop a process for assessing the need for a health facility prior to insuring an applicant based on the thorough survey of all existing health facilities.
    - ♦ Articulate guiding principles and priorities.
    - ♦ Describe loan insurance practices.
    - ♦ Create a comprehensive "status of borrowers," including the stages of default, late payments, debt service, reserve fund invasion and fund payment.
    - ♦ Evaluate and compare program activity since the last state plan and since the inception of the program.
    - ♦ Establish a maximum level of acceptable insurance risk based on the applicant's credit history, financial strength, cash flow and ability to repay debt.
    - ♦ Establish a risk criteria matrix, which will rank and score each applicant and ultimately determine whether to insure an applicant's loan insurance. The

acceptable level of insurance risk should be flexible enough to allow marginally unacceptable applicants if they provide a public benefit.

- Evaluate practices of bond insurers and debt rating companies to determine the best and most suitable practices used by these organizations and adopt such practices.
- Develop a formal monitoring program to ensure consistent monitoring of all borrowers and early detection of those experiencing financial difficulties.
- Develop a system of warning letters, financial penalties or other appropriate actions, and execute them when a borrower does not comply with submission requirements on a timely basis.
- Establish a standard process of thoroughly reviewing borrowers' financial statements, budgets, auditor's management letters and health facility utilization trends.
- Compare such data to industry trends and other borrowers in Cal-Mortgage's portfolio.
- Perform regular structured site visits to borrowers' facilities.
- Monitor borrowers to assess compliance with Cal-Mortgage requirements to fulfill community service obligation and report the level of compliance to the Legislature within 90 days after the close of each fiscal year.
- Restrict appointed consultants, turnaround specialists and receivers to those with specific experience with health facilities and require approval by both OSHPD and the Secretary of the California Health and Human Services Agency prior to appointment.
- Encourage a dialogue with existing local and regional health advocacy organizations to better understand local and regional health needs.
- Disallow the inappropriate use of the Cal Mortgage loan insurance program in guaranteeing capital improvements and operating revenues purely to encourage facility acquisitions by other entities

2) **The Treasurer, the Department of Finance and The California Health and Human Services should collectively evaluate and determine the appropriate agency to oversee the Cal-Mortgage facilities loan insurance program and report their recommendations to the Legislature prior to July 1, 2000.**
3) **The OSHPD and Cal-Mortgage should explore the feasibility of creating a network among health care organizations insured by the program, such that they may cooperatively make purchases, referrals and contracts and potentially reduce the cost of health care.**